TEXAS
Health and Human
Services Commission

Date:
Eligibility Specialist:
Office address and phone no.:

Name and Address of Provider:

Provider Notice of Incurred Medical Expense Decision

Name of Client:	Client No.:
Facility Name and Address:	
Provider Name and Address:	

The incurred medical expense is approved.

The request for _____ is approved.

Total amount approved _____

The client's co-payment amount is adjusted effective _____ and ending _____ .

The incurred medical expense is denied.

The request for _____ is not approved.

Comments:

To safeguard confidentiality, co-payment amounts are not given to providers without written authorization from a client/authorized representative.